SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 10, 2012

9:30 AM or
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)

Part 1 of the Agenda
(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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VOTE ONLY CALENDAR, Pages 3-10

A. 0530 California Health and Human Services Agency

1. Extend Sunset Date for Office of HIPPA Implementation

Budget Issue. Through a Spring Finance Letter, the Administration proposes to extend the sunset date for the California Office of Health Information Integrity (CalOHII) from January 1, 2013 to June 30, 2016. Additionally, CalOHII proposes a reduction in its budget of $751,000 for the elimination of two positions and a reduction in contract funds.

Under this proposal, total funding for CalOHII would include $1.973 million General Fund, $1.2 million Reimbursements, and $10.5 million from the California Health Information Technology and Exchange Funds and total positions would be 19.

Background. CalOHII is tasked with overseeing all statewide activities to comply with the federal Health Insurance Portability and Accountability Act (HIPPA). Specifically, CalOHII is tasked with:

- Statewide leadership, coordination, policy formation, direction, and oversight responsibilities by impacted state departments;
- Full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on HIPPA implementation efforts; and
- Responsibility for determining which provisions of state law concerning personal health information are preempted by HIPPA for state agencies.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item. No issues have been raised.

B. 2400 Department of Managed Care

1. Premium Rate Review Cycle II Federal Grant

Budget Issue. The DMHC requests 2 two-year limited-term positions and an increase of federal expenditure authority of $755,000 for 2012-13, $691,000 for 2013-14, and $72,000 for 2014-15 to administer the Health Insurance Premium Rate Review Cycle II Federal Grant. These positions and spending authority would be used to enhance DMHC's capabilities in collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the federal government, and disclosing rate information to consumers.

This item was discussed at the Subcommittee#3 Hearing on March 8, 2012: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/382012Sub3DMHC_OSHPD_DPH_DHCS_FamilyHealth.pdf

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item. No issues have been raised.

C. 4140 Office of Statewide Health Planning and Development

1. Retention and Evaluation Activities (REA) Initiative

Budget Issue. Through a Spring Finance Letter, OSHPD requests an increase in federal fund expenditure authority of $162,000 in 2012-13 for the REA Initiative. Current year funding for this project was approved through the Section 28 Budget Revision process. The REA Initiative requires grant funds to be expended by September 30, 2013.

Background. The REA Initiative is a federally funded program that allows states to perform activities to retain clinicians in underserved communities and analyze the impact of such activities. OSHPD's Primary Care Office is administering this initiative.

Subcommittee Staff Comment and Recommendation—Approve. Approve Administration's proposal.

D. 4260 Department of Health Care Services

1. HIV Transition Incentive Program

HIV Transition Incentive Program. In order to assure that persons with HIV make their transitions of coverage from Ryan White to the Low Income Health Program (LIHP) with continuity of quality care, without loss of either core or other critical services, and with minimal disruption to critical patient/provider relationships, the Department of Health Care Services submitted a section 1115 Demonstration amendment to create the HIV Transition Incentive Program. Under the HIV Transition Incentive Program, $150 million would be available annually in 2011-12 and 2012-13 and $75 million in 2013-14 for the development of projects that support the LIHP systems' efforts to address the continuity of care, care coordination, and coverage transition issues for persons with HIV. DHCS is still working with the federal government on the requested amendment.

At the March 8, 2012 Subcommittee #3 hearing, the Subcommittee approved the following action:

- Add a Health Program Specialist II position at the Department of Health Care Services to manage the HIV Transition Incentive Program and coordinate with DPH's Office of AIDS. This position would be funded using county funds (via certified public expenditures) and federal funds.

Subcommittee Staff Comment and Recommendation. Based on discussions with the department, it is recommended to redirect an existing vacant Health Program Specialist II position created for LIHP instead of adding a new position.

E. 4265 Department of Public Health

1. Healthcare Acquired Infections Public Reporting

Budget Issue. The DPH proposes an increase of $493,000 Licensing and Certification Fund for four positions (that will be redirected from within DPH) for the statutorily required public reporting of health care associated infections (HAIs) by hospitals. These positions would be funded through an increase in licensing fees paid by General Acute Care Hospitals (GACHs).

These positions would be used to meet the workload associated with the increase in the number of surgical procedures that must be reported by hospitals. When the program was created, DPH determined that only three types of surgical site infections must be reported. However, DPH's recent interpretation of statute increased the number of reportable types of surgical site infections to 29; thereby causing a more than 12-fold increase in workload (from 71,000 surgical procedures to more than 900,000).

Background. DPH created the HAI Program in 2009 to implement (1) SB 739 (Spier), Statutes of 2006; (2) SB 158 (Florez), Statues of 2008; and (3) SB 1058 (Alquist), Statutes of 2008. The program is required to take specific actions to protect against HAI in GACHs statewide, these include:

- Receiving reports from hospitals on implementation of infection surveillance, infection prevention process measures, and the occurrence of HAI.

- Providing reports with the above information to the public on an annual basis.

The program originally included 12 authorized positions.

According to the department, in California's GACHs, HAIs account for an estimated 240,000 infections, 13,500 deaths, and $3.1 billion in excess health care costs annually.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal and workload is justified.

2. Reduction of Preventable Medical Errors and Medication Errors Contract

Budget Issue. The DPH proposes to fund a contract with the University of California to support efforts to reduce preventable medical errors and associated health care costs in licensed health care facilities. The quality improvement activities would focus on medication errors and aim to identify solutions to medication safety system vulnerabilities. The contract would be for a total of $1 million spread equally over three fiscal years. The funding for this contract would come from the Internal Departmental Quality Improvement Account (IDQIA).

The purpose of the contract is to:

- Identify common medication safety vulnerabilities.

- Identify solutions (e.g., evidence-based practices) to medication safety vulnerabilities that are proven to reduce medication errors.
- Identify and build upon current medication safety activities occurring at the hospital and long-term care level through a collaborative approach.
- Identify and propose mechanisms to promote rapid dissemination of proven medication safety strategies.
- Reduce the number of medication errors occurring in health care facilities.

Background. SB 1312 (Alquist), Statutes of 2006, authorized DPH to impose penalties for hospitals for deficiencies constituting immediate jeopardy. These penalties are deposited into the IDQIA. Funds in the IDQIA must be expended for quality improvement activities initiated by the Licensing and Certification (L&C) Program at DPH.

Between January 2007 and November 2010, L&C issued 170 administrative penalties for hospital deficiencies constituting immediate jeopardy. Medication error/pharmacy error was the primary cause for an administrative penalty, accounting for 48 penalties, or 28.2 percent of all issued administrative penalties.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal and use of these funds to identify strategies to reduce the number of medication errors is justified as this is one of the most commonly cited penalties.

3. Close Southern California Laboratory

Budget Issues. The DPH proposes to close its Southern California Laboratory (Temple Street building) due to health and safety concerns related to the building's code and seismic deficiencies. The closure of the Temple Street building would generate savings of $180,000 ($57,000 General Fund) in 2012-13 and $360,000 ($114,000 General Fund) in future years from various funds.

DPH programs would transition out of the building on July 1, 2012.

Background. The DPH owns and operates two laboratory/office buildings: one in Northern California (the Richmond Laboratory) and one in Southern California (the Temple Street building). In 1988, the Department of Health Services (now DPH) purchased the Temple Street building for $1.3 million. Four DPH programs occupied this building: the Environmental Laboratory Accreditation Program, the Environmental Management Branch, the Food and Drug Branch, and the Drinking Water Radiation Laboratory Branch. In addition, DPH leases space to the Department of Toxic Substance Control's (DTSC) Environmental Health Laboratory Program.

Three separate infrastructure studies of the Temple Street building have been conducted. The first two studies, completed in 1986 and 1991, identified numerous deficiencies and determined that the building did not meet various building standards. The third study,

conducted in 2006, concluded that it would not be cost-effective to renovate the existing building given its many structural deficiencies.

Additionally, both DPH and DTSC have received health and safety complaints from employees and grievances from the California Association of Professional Scientists. Since 2009, DPH has been systematically relocating DPH programs out of the Temple Street building into other DPH space in Southern California.

Subcommittee Staff Comment and Recommendation—Approve. Given the health and safety risks posed by this building, it is recommended to approve this item. De-commissioning costs for the Temple Street building are not yet know and cannot be determined until all occupants are out of the building. (It is anticipated that it DTSC might need up to one year to vacate the premises.)

4. Special Fund Efficiencies

Budget Issue. Through a Spring Finance Letter, DPH requests the following changes:

a. **Health Statistics Special Fund.** Reduce expenditures of the Health Statistics Special Fund by $534,000 in order keep expenditures in line with revenue.

b. **Water Device Certification Program.** Eliminate the Water Device Certification Program (-$382,000). Currently, water devices require third party approval in addition to State certification. That approval is provided by an independent testing organization that has been accredited by American National Standards Institute (ANSI) or by the federal government.

   California is only one of six states nationally that require water device products to have State certifications. According to DPH, eliminating California certification will have minimal impact on public health, as products will still require third party approval before being offered for sale in California.

c. **Registered Environmental Health Specialist Fund.** Reduce expenditures of the Registered Environmental Health Specialist Fund by $68,673 to reflect the reduced workload associated with a reduction in the number of applications to process.

d. **Retail Food Safety and Defense Fund.** Eliminate the existing Retail Food Safety and Defense Special Fund and redirect the deposits of user fees (about $21,000) for retail food related activities collected by DPH to the existing Food Safety Special Fund. DPH is charged with ensuring the safety of the food supply, including responsibilities in the area of retail food safety. The California Retail Food Code provides DPH with the responsibility to oversee the statewide implementation of a retail food safety program with primary enforcement of the retail food code conducted by local health departments.

Depositing retail food safety related user fees into this fund is consistent with the existing use of the Food Safety Fund and will provide DPH and the state with some cost savings through the elimination of one special fund that has to be monitored and tracked on an ongoing basis.

e. **Recreational Health Fund Program.** Eliminate the Recreational Health Fund and Program ($237,000). DPH notes that while the program was designed to sunset in 2014, its proposed elimination with the 2012-13 Budget is supported by the work already completed by DPH. This includes providing statewide information and guidance memos to Local Environmental Health Departments (LEHDs) for their use and for distribution to owners of public pools and spas and their contractors, as well as working with the California Conference of Directors of Environmental Health (CCDEH) to develop a pool owners compliance form and instructional materials distributed to LEHDs and pool owners, operators, and contractors. Eliminating this program at the state level will place the responsibility of implementing the elements contained within statue related to the federal Virginia Graeme Baker Pool and Spa Safety Act and federal safety standards with the LEHDs.

f. **California Prostate Cancer Research Fund.** Eliminate the California Prostate Cancer Research Fund. This fund was created to deposit voluntary contributions made by taxpayers in excess of their tax liability. This fund did not collect enough voluntary contributions to remain on the State Income Tax check-off list. No further revenues are being generated.

g. **Sexual Violence Victim Services Fund.** Eliminate the California Sexual Violence Victim Services Fund. This fund was created to deposit voluntary contributions made by taxpayers in excess of their tax liability. This fund did not collect enough voluntary contributions to remain on the State Income Tax check-off list. No further revenues are being generated.

Budget Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with these proposals.

F. 4440 Department of Mental Health

1. Transition of Community Mental Health – Technical Adjustments

Budget Issue. Through a Spring Finance Letter, the Department of Mental Health (DMH) is requesting a technical adjustment on the transfer of resources not identified in prior budget change proposals supporting the transition of community mental health functions from DMH to other state entities. This request proposes to:

- Add two positions and $189,000 ($94,500 General Fund) to the Department of Health Care Services (DHCS) (and the corresponding reduction to DMH) to reflect a transfer of resources from DMH to DHCS to support account receivable activities.
- Increase $865,000 General Fund to DMH (and the corresponding reduction to DHCS) to reflect a correction on the share of federal financial participation previously identified.

Subcommittee Staff Comments and Recommendation—Approve. These are technical changes and recommended for approval.

ISSUES FOR DISCUSSION

A. 4265 Department of Public Health

1. Licensing and Certification (L&C) Program

Background. The Licensing and Certification (L&C) Program develops and enforces State licensure standards, conducts inspections to assure compliance with federal standards for facility participation in Medicare and/or Medi-Cal, and responds to complaints against providers licensed by the DPH.

In 2006, the L&C Program began a transition to migrate from General Fund support to a fee-based program, coupled with applicable federal funding. Only State departments that operate long-term care facilities are appropriated General Fund support for the purpose of licensing and certification activities. Existing statute provides the framework for calculating the annual licensing and certification fees for each of the various health care facilities.

Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain "credit" adjustments. The DPH notes that these "credits" are most likely one-time only and that when fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The "credits" are applied to offset fees for 2012-13 and total $12.2 million. They are as follows:

- $3.7 million credit for miscellaneous revenues for change in ownerships and late fees collected in 2010-11.
- $8.5 million credit from the program reserve (which is largely a result of vacancies due to the state's hiring freeze).

The fees must also take into consideration various incremental cost adjustments for 2012-13, including budget change proposals (discussed above in the Vote Only section of this Agenda), employee retirement and worker's compensation, facility space for field offices and related aspects.

Additionally, in order to prevent major variations in fee amounts year to year, DPH is ensuring that a facility type's fee increases or decreases by only 5 percent.

The DPH Fee Report of February 2012 proposes slight changes to fees as shown in the Table below.

Table: Proposed Licensing and Certification Fee Schedule (February 2012)

Facility Type	Fee Category	2011-12 Fee	Proposed Fee 2012-13	Difference
Acute Psychiatric Hospitals	per bed	$280.61	$266.58	-$14.03
Adult Day Health Centers	per facility	$4,384.13	$4,164.92	-$219.21
Alternative Birthing Centers	per facility	$3,131.83	$2,975.27	-$156.56
Chemical Dependency Recovery	per bed	$187.01	$191.27	$4.26
Chronic Dialysis Clinic	per facility	$3,766.62	$3,578.29	-$188.33
Community-Based Clinics	per facility	$756.17	$718.36	-$37.81
Congregate Living Facility	per bed	$297.14	$312.00	$14.86
Correctional Treatment Centers	per bed	$546.38	$573.70	$27.32
General Acute Care Hospitals	per bed	$280.61	$266.58	-$14.03
Home Health Agencies	per facility	$4,542.60	$4,315.47	-$227.13
Hospice	per facility	$4,795.92	$4,641.96	-$153.96
Intermediate Care Facility (ICF)	per bed	$297.17	$312.00	$14.83
ICF—DD Habilitative, DD Nursing	per bed	$552.76	$580.40	$27.64
ICF-Developmentally Disabled	per bed	$552.76	$580.40	$27.64
Pediatric Day Health/Respite	per bed	$197.90	$188.01	-$9.89
Psychology Clinic	per facility	$1,406.34	$1,476.66	$70.32
Referral Agencies	per facility	$4,597.90	$4,368.01	-$229.89
Rehabilitation Clinic	per facility	$247.00	$259.35	$12.35
Skilled Nursing Facility	per bed	$297.14	$312.00	$14.86
Special Hospitals	per bed	$280.61	$266.58	-$14.03
Surgical Clinic	per facility	$2,368.57	$2,487.00	$118.43

Background on Fee Methodology. Licensing fee rates are structured on a per "facility" or "bed" classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—Licensing and Certification Special Fund.

The fee rates are based on the following activities:

- Combines information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).
- Calculates the State workload rate percentage of each facility type to the total State workload.
- Allocates the baseline budget costs by facility type based on the State workload percentages.
- Determines the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Divides the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The DPH Fee Report provides considerable detail regarding these calculations, as well as useful data on L&C workload associated with the various types of health care facilities, along with a clear description regarding the details of the methodology. This report can be found at:

http://www.cdph.ca.gov/pubsforms/fiscalrep/Documents/LicCertAnnualReport2012.pdf

Questions. The Subcommittee has requested the L&C Program to respond to the following question:

1. Please provide a brief summary of the L&C Fees, including the key credits and adjustments.

a. Special Fund Efficiencies – Eliminate State Mandates for Health Facilities

Budget Issue. Through a Spring Finance Letter, DPH proposes to eliminate current State mandates regarding health facility inspections and complaint investigations and; consequently, to eliminate 25 Health Facility Evaluator Nurses (HFENs) and $4.6 million from the Licensing and Certification Fund.

Specifically, the proposal seeks to make the following changes:

- Delete the requirement that L&C inspect (unannounced) health facilities to ensure they are in compliance with state laws and regulations at least every two years. Remove the requirement that for certain types of hospitals, the inspection team must include a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections.

- Eliminate the State mandated timeframe in which L&C must respond to a complaint and instead use federal timeline requirements.

Complaint Type	State Requirement	Federal Requirement
Immediate Jeopardy	24 hour	48 hour
Non-Immediate Jeopardy—High	10 day	10 day
Non-Immediate Jeopardy—Low	10 days	At next visit to facility for certification

- Eliminate the State mandated timeframe in which L&C must complete a complaint investigation (45 days). Since federal law does not specify a timeframe, there would be no timeframe in which L&C must complete a complaint investigation.

- Eliminate State law that requires that inspections of long-term health care facilities (nursing homes) that are certified by the Medicare program or the Medicaid program include a survey for California statutes and regulations to the extent that California statutes and regulations provide greater protection to residents, or are more precise than federal standards, as determined by the department.

- Eliminate the State requirement that Adult Day Health Care Centers be inspected at least every two years. DPH would retain the authority to inspect these centers as needed.

- Eliminate the State requirement that clinics (primary care, dialysis, surgery, rehabilitation, alternate birthing centers, psychology, and pediatric day health respite care) be inspected at least once every three years.

Background—Health Facilities. SB 1301 (Alquist), Statutes of 2006, requires the reporting of serious medical errors (adverse events) to DPH and establishes timeframes for both reporting of these events and follow-up investigations. The law also requires L&C to make an on-site inspection within 48 hours of receipt of a written or oral complaint that indicates an ongoing threat of imminent danger of bodily harm or death.

Background—Long-Term Care Facilities/Nursing Homes. SB 1312 (Alquist), Statutes of 2006, requires the DPH to inspect all licensed long-term care health facilities to ensure compliance with state laws and regulations to the extent that those standards provide greater protection to residents or are more precise than federal standards.

Prior to the passage of SB 1312, long-term care health facilities that were certified to participate in the Medi-Cal Program were exempt from periodic state licensing inspections. SB 1312 removed that exemption.

To ensure maximum effectiveness of inspections conducted, SB 1312 also mandated the L&C Program to identify all state law standards for staffing and operation of long-term care health facilities.

Examples of state standards that provide greater protection to residents or are more precise than federal standards include:

- Requirements on the administration of medications.
- The use of restraints only upon written order by a physician or other person lawfully authorized to prescribe care.
- Requirements on health records and admission records.

Federal and State Survey Processes. The survey protocols for conducting a federal certification survey are prescribed by the federal CMS. The DPH surveyors are "graded" for compliance with those protocols by periodic and direct observations by the federal CMS specialists. The DPH performance is measured by the average length of time taken for the federal survey, the timeliness of submitting the survey findings to the facility, and the timeliness of obtaining an acceptable plan of correction.

The federal CMS does not permit violations of state licensing standards to be included in the federal certification survey documents. Failure to comply with federal standards can jeopardize the federal grant funds the state receives for the L&C Program.

Table: Skilled Nursing Facilities - Number of Surveys and Deficiencies

State Fiscal Year	# of State Re-licensure Surveys	# of State Deficiencies Cited	Average # of State Deficiencies Cited per Survey	# of Federal Re-certification Surveys	# of Federal Deficiencies Cited	Average # of Federal Deficiencies Cited per Survey
2007-08	53	286	5.4	947	16,088	16.99
2008-09	90	470	5.22	1,014	17,589	17.35
2009-10	128	783	6.12	913	15,504	16.98
2010-11	347	2,138	6.16	929	15,890	17.1
Total	**618**	**3,677**		**3,803**	**65,071**	

Background—L&C Investigation Workload. As of March, 2012, L&C's workload related to long-term care facilities includes approximately:

- 4,000 complaint investigations initiated but not closed.
- 2,100 facility-reported incident investigations that have not been initiated.
- 4,500 facility-reported incident investigations that have been initiated but not closed.

As of March 2012, L&C's workload related to non-long term care facilities (primarily hospitals) includes approximately:

- 2,200 complaint investigations that have not been initiated.
- 2,300 complaint investigations that have been initiated but not closed.
- 4,000 facility-reported incident investigations that have not been initiated (approximately 850 are Adverse Events, of which about 554 are pressure ulcers).
- 3,500 facility-reported incident investigations initiated but not closed (approximately 1,000 are Adverse Events, of which approximately 560 are pressure ulcers).

According to DPH, complaints and facility-reported incidents that have not been initiated largely include reports that do not indicate a probability of harm (e.g., billing or privacy issues). L&C is not in compliance with the mandate to close investigations of about 530 Adverse Events within 45 days of initiation.

Subcommittee Staff Comment and Recommendation—Reject. State laws provide greater protections for California residents. These protections address patient safety and quality of care and as research shows, are key components of reducing medical costs. This proposal provides no relief to the General Fund, nor does it offset facilities licensing fees because these savings would remain in the Licensing and Certification Fund reserve. It is recommended to reject this proposal.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Please provide an overview of this proposal.

2. Please provide examples of state safeguards that provide greater protection to residents of nursing facilities that are more stringent than federal requirements.

3. What would be the impact on patients with this proposal?

b. L&C's Role in the Money Follows the Person Program

Oversight Issue. Concerns have been raised that L&C survey staff are not proactively reviewing data and follow-up action taken by staff at nursing facilities regarding a nursing home resident's desire to return back to the community.

Background. California received a Money Follows the Person (MFP) grant in January 2007 and developed the California Community Transitions (CCT) project. This grant is to be used to target Medicaid enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal is to offer a menu of social and medically necessary services to assist them to remain in their home or community environments. In 2010, MFP transitioned 205 individuals from a health facility into the community.

On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated local community organizations.

By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

On March 22, 2012, this Subcommittee approved a budget proposal by the Department of Health Care Services to expand the Money Follows the Person program into additional counties.

Subcommittee Staff Comment. Given DHCS' effort to expand Money Follows the Person to additional counties in the state and the enhanced federal funding that is associated with returning a person to the community under this program, it is critical that all state department staff coordinate their efforts to ensure the success of the MTP program.

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Do L&C surveyors monitor how a nursing home resident responds to this question and whether or not nursing facility staff make the appropriate referral to the community liaison?

2. Are there any proactive steps DPH could take (e.g., district office memos) to encourage surveyors to review this information and ensure that nursing facility staff are taking the appropriate action?

2. Transfer of Direct Service Programs to Department of Health Care Services

Budget Issue. The DPH proposes to transfer three direct services programs to the Department of Health Care Services (DHCS) effective July 1, 2012. These programs are the Every Women Counts (EWC) Program, the Prostate Cancer Treatment Program, and the Family Planning Access Care and Treatment (FPACT) Program. These programs would be transferred to the Health Care Benefits and Eligibility Division at DHCS.

DPH proposes to transfer $16.5 million General Fund, $77.2 million federal funds, and $33.3 million in special funds and 33.6 positions to DHCS. (There is no proposed reduction to funding or positions.)

The Administration notes that these three programs provide direct health care services to individuals and have eligibility requirements designed to serve low-income Californians, thus align more closely with the scope of services provided by DHCS. Additionally, as federal health care reform is implemented, the transferring of these programs to DHCS will facilitate a more seamless transition to Medi-Cal enrollment and maximize opportunities to leverage federal Medicaid funds to cover the costs currently supported with state funds.

Background. When the Department of Health Services was split in 2007 into DHCS and DPH, DPH retained EWC, the Prostate Cancer Treatment Program, and FPACT because of the strong nexus between these programs and DPH's core preventative health and outreach activities.

Every Woman Counts Program. EWC provides cancer screening services for low income under-insured and uninsured women. Through EWC, women receive free clinical breast exams, mammograms, other breast cancer diagnostic testing, pelvis exams, and Pap tests, with the intended outcome to reduce breast and cervical cancer deaths. EWC enrolls women age 25 and older for cervical cancer prevention screening and women age 40 and older for breast cancer screening and diagnostic services.

Prostate Cancer Treatment Program. The Prostate Cancer Treatment Program helps underserved men receive free prostate cancer treatment services through Improving Access, Counseling and Treatment (IMPACT) for Californians with Prostate Cancer program. UCLA has administered the IMPACT program since 2001.

Family Planning Access Care and Treatment Program. FPACT was established by the Legislature in 1996 to fill a gap in health care for underinsured and uninsured. The objectives of this program are to reduce the rate and cost of unintended pregnancies, increase access to publicly funded family planning for low-income Californians, increase the use of effective contraceptive methods by clients, and promote improved reproductive health.

Subcommittee Staff Comment and Recommendation—Approve. Moving these direct health services programs to DHCS makes sense particularly with federal health care reform. No issues have been raised regarding this proposal.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Please provide an overview of this proposal.

2. How does the Administration plan to ensure that the public health focus of these programs is not lost?

3. How does this proposal position the State in preparation for health care reform?

3. Kids' Plate – Childhood Injury Prevention

Budget Issue. The budget includes $494,000 in local assistance from the Child Health and Safety Fund for DPH. According to the Administration, these funds cannot be distributed to local entities because DPH does not have administrative expenditure authority over the funds (there is no state operations funding for the department for these funds).

Background. AB 3087 (Chapter 1316, Statutes of 1992) established the *Have a Heart, Be a Star, Help Our Kids* specialized license plate program. Revenues from these license plate fees, totaling $4.1 million in 2009-10 and $4.0 million in 2010-11, are deposited into the Child Health & Safety Fund. State law (Welfare & Institutions Code Sections 18285 and 18285.5) specifies how those revenues are distributed. Currently, the first 50 percent supports specific Department of Social Services responsibilities for child day care licensing. Of the remaining 50 percent, up to 25 percent supports child abuse prevention and the rest supports programs that address injury prevention. It should be noted that under a Department of Social Services' budget proposal, more funds would be allocated for child day care licensing activities to achieve $501,000 in General Fund savings.

DPH has been receiving funds from this license plate program since 1996-97 and entered into a contract with San Diego State University Research Foundation (SDSURF) to distribute these funds to local organizations for activities related to the prevention of unintentional childhood injuries and accidents. When the department went to renew its contract with SDSURF in July 2010, the Department of General Services (DGS) raised two issues with the contract. First, DGS indicated that the nature of the contract was creating a role for SDSURF as a fiscal agent for the state (since SDSURF was not a state entity, but rather a nonprofit associated with the San Diego State University) and that this was not appropriate. Second, DGS argued that DPH was contracting out work that could be done by state employees. These issues could not be worked out, and; consequently, this contract expired in 2010-11.

Since the end of the grant program contract managed by SDSURF, DPH has initiated one-time-only grants to conduct small-scale projects like Bike to School Day Events, childhood pedestrian safety education and awareness, child passenger safety fitting stations, and education for parents on safe sleeping practices and on the need for pool barriers. The DPH secured assistance from outside agencies/partners to help with outreach to solicit applications and in preparing agreements. DPH indicates that this method for awarding grants is not sustainable as an ongoing approach.

Subcommittee Staff Comment and Recommendation. In order to ensure that these funds are distributed to local entities for childhood injury prevention efforts and to maximize the amount of funding available for the local entities, the following actions are recommended:

1. Allow for up to 5 percent of DPH's allocation from Child Health and Safety Fund to be used for state operations for administration.

2. Direct DPH to create a regional grant program for these funds. DPH would issue a Request for Assistance (RFA) for entities interested in regionally coordinating the distribution of this grant funding. The regional entity would also be responsible for providing actual services (in order to avoid DGS' concerns discussed above). The goal of this regional grant program would be to maximize the amount of funding local entities receive for activities related to childhood injury prevention, such as child passenger safety, bicycle safety, and unintentional injury prevention. There would be no more than three regions (north, south, and central) to reduce the amount of state funds necessary to execute these grants. Additionally, it should be noted that since these are local assistance funds, they are not required to be bid out competitively, per section 3.17 of the State Contract Manual. In order to reduce the administrative overhead of this grant program, the regional grantees could be awarded under a two-year term and have the option to extend the contract for an additional two-years based on satisfactory performance.

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide a brief overview of this issue.

2. Does the Administration have any concerns with the Subcommittee Staff recommendation?

B. 4140 Office of Statewide Health Planning and Development

1. Mental Health Loan Assumption Program (MHLAP) Increase Awards

Budget Issue. Through a Spring Finance Letter, OSHPD requests an increase of $5.1 million (Mental Health Services Act Fund) for loan assumption awards and two new permanent positions to manage the increased workload associated with the doubling of awards. The increased funding allows the Health Professions Education Foundation's Mental Health Loan Assumption Program to double the annual number of awards from 600 to 1,200 and expand the eligibility criteria to better meet the workforce needs of each county's public mental health system.

Background. Approved by voters in 2004, the Mental Health Services Act (MHSA) imposes a 1 percent tax on personal income in excess of $1 million to support the public mental health system. One of the components of the MHSA is the Workforce, Education, and Training (WET) Program. WET assists counties in developing and maintaining a culturally competent workforce capable of providing client and family-driven services. MHLAP is one of the programs funded by WET. MHLAP provides loan repayments of up to $10,000 to mental health practitioners in exchange for a 12-month service obligation in California's public mental health system. Eligible professions include licensed psychologists, registered psychologists, postdoctoral psychological assistants, licensed clinical professional counselors, licensed marriage and family therapists, and others.

Funding for awards has increased from $2.5 million in 2008-09 to $5 million in 2010-11 and would increase to $10 million in 2012-13 with approval of this proposal. Awards are reviewed and scored by MHLAP's Advisory Committee, which is comprised of representatives of the County Mental Health Directors Association, licensing board, academia, and community organizations.

Table: Summary of Mental Health Loan Assumption Applications and Funding

Workload Measure	2008-09	2009-10	2010-11	2011-12	Total
Applications Received	1,065	1,269	1,011	1,659	5,004
Applications Awarded	283	309	474	550-600	1,666
Amount Requested	$58.3 million	$76.7 million	$66.4 million	$105.6 million	$307.1 million
Amount Awarded	$2.2 million	$2.3 million	$4.4 million	$5.0 million	$13.9 million

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. The demand for loans (as displayed in the table above) for mental health professionals willing to serve in the public mental health system is evident.

Questions. The Subcommittee has requested OSHPD to respond to the following question:

1. Please provide an overview of this proposal.

C. 2400 Department of Managed Health Care

1. Transfer Department of Managed Health Care and Office of Patient Advocate to the California Health and Human Services Agency

Budget Issue. Through a Spring Finance Letter and in compliance with AB 992 (Monning), Statutes of 2011, the Administration proposes to transfer DMHC to the California Health and Human Services Agency (CHHSA) and to separate the Office of Patient Advocate (OPA) from DMHC to become an office within CHHSA.

Although AB 922 specifies a January 1, 2012 transfer of DMHC from the Business and Transportation Agency to CHHSA, the Administration is proposing to make this transfer effective July 1, 2012, as it notes that from the state budgeting perspective it is more efficient to reflect the transfer of the budget appropriation at the beginning of a fiscal year.

Specifically, this proposal requests:

1. The transfer of DMHC's budget authority of $53.097 million and 366.0 authorized positions from the Business, Transportation and Housing Agency to CHHSA;

2. The separation of the Office of Patient Advocate (OPA) from the DMHC to become an independent entity within the CHHSA, transferring its budget authority of $2.184 million and 12.0 positions from the DMHC to the OPA;

3. The transfer of 1.0 DMHC position to the Department of Health Care Services (DHCS) and $242,000 to the OPA to reimburse DHCS for its IT services (and a corresponding increase in DHCS' reimbursement authority);

4. The transfer of 1.0 DMHC position to the Department of Social Services (DSS) and $80,000 to the OPA to reimburse DSS for its administrative services support.

Background. The OPA was created in AB 78 (Gallegos), Statutes of 1999, in order to help health plan enrollees secure the health care services to which they are entitled. The OPA develops and distributes educational materials describing enrollee rights and responsibilities, and compiles and publishes an annual public quality of care report card on health plans.

AB 922 establishes the Office of Patient Advocate Trust Fund to support OPA's current and expanding activities. Funding for OPATF will be provided by the transfer of monies from the Managed Care Fund and the California Department of Insurance's (CDI's) Insurance Fund such that funding contributions will be based on the number of covered lives enrolled in health plans regulated by the DMHC and enrolled in health insurance policies regulated by the CDI in proportion to the total number of covered lives in California. This applies to both full-service health plans and specialty health plans. It is anticipated that CDI will contribute about 10.5 percent of funding for OPA.

Additionally, AB 922 expands OPA's duties effective January 1, 2013. These expanded duties include:

- Providing outreach and education about health care coverage, including how to apply, costs, renewal processes, transitions between programs and information and assistance with different coverage programs;

- Coordinating with other state and federal agencies on implementation of the Affordable Care Act (ACA);

- Referring consumers to the appropriate regulatory agencies for filing complaints, grievances, claims, or payment problems; and,

- Tracking and analyzing data on consumer issues, including demographic data, source of coverage, regulator, complaint resolution, and timeliness of resolution; the OPA will provide this data to the federal government in accordance with the ACA.

The Administration is not seeking increased expenditure authority or positions for these expanded duties at this time and anticipates that starting in January 2013, OPA will work with CHHSA to develop a plan to coordinate its efforts with those of DHCS, the Health Benefit Exchange, the Managed Risk Insurance Boards, and local entities.

Subcommittee Staff Comment and Recommendation—Approve. This proposal implements AB 922 and helps prepare the state for federal health care reform. It is recommended for approval.

Questions. The Subcommittee Staff has requested the Administration to respond to the following question:

1. Please provide an overview of this proposal.